

Rare Disease Medications

Member and Medication Information (required)		
Member ID:	Member Name:	
DOB:	Weight:	
Medication Name/ Strength:	Dose:	
Directions for use:		
Provider Information (required)		
Name:	NPI:	Specialty:
Contact Person:	Office Phone:	Office Fax:
FAX FORM AND RELEVANT DOCUMENTATION INCLUDING: LABORATORY RESULTS, CHART NOTES and/or UPDATED LETTER OF MEDICAL NECESSITY TO 855-828-4992		

Criteria for Approval (all criteria must be met and documented in submitted chart notes):

- ☐ Medication is prescribed by or in consultation with a physician who specializes in the disease treatment.
 - Specialist name and credentials: _____
- ☐ Documented diagnosis: _____ Chart note page #: _____
 - Genetic testing, if applicable. Chart note page #: _____
 - Other confirmation testing, if applicable. Chart note page #: _____
- ☐ Include latest treatment guidelines or compendia treatment recommendations, if applicable, with request.
- ☐ Use must follow FDA-approved labeling (*including monitoring for boxed warnings and contraindications*).
 - Applicable monitoring for boxed warnings. Chart note page #: _____
- ☐ If current treatment standards recommend other treatment modalities or interventions prior to use of the requested drug, document the use of appropriate first line treatments or interventions.
 - Treatment/Interventions: _____ Chart note page #: _____
- ☐ Off Label or Compendia Use Additional Criteria: Requests for any off-label indications must be supported by at least one (1) major multi-site study or three (3) smaller studies published in JAMA, NEJM, Lancet or other peer review specialty medical journals within the most recent five (5) years. Supporting documentation must be included. Compendia use must be recommended by generally-accepted compendia such as American Hospital Formulary Service Drug Information (AHFS), United States Pharmacopeia-Drug Information (USP-DI), the DRUGDEX Information System, and the peer-reviewed medical literature.
- ☐ Additional drug-specific criteria may apply and may guide adjudication; additional information may be needed. See addendum for details, page 2.

Re-authorization Criteria, if applicable:

Updated letter of medical necessity or updated chart notes demonstrating positive clinical response

Initial Authorization: Up to six (6) months, if applicable**Reauthorization:** Up to one (1) year, if applicable**Note:**

- ❖ Use appropriate HCPCS code for billing if applicable
Coverage and Reimbursement code look up: <https://health.utah.gov/stplan/lookup/CoverageLookup.php>
HCPCS NDC Crosswalk: <https://health.utah.gov/stplan/lookup/FeeScheduleDownload.php>

PROVIDER CERTIFICATION

I hereby certify this treatment is indicated, necessary and meets the guidelines for use.

Prescriber's Signature_____
Date

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

Brand (generic)	Additional Criteria
Luxturna (voretigene)	<p>What is the patient's diagnosis:</p> <p><input type="checkbox"/> Biallelic RPE65 mutation-associated retinal dystrophy</p> <p><input type="checkbox"/> Other, please specify: _____</p> <p>Which eye is being treated:</p> <p><input type="checkbox"/> Left eye <input type="checkbox"/> Right eye <input type="checkbox"/> both eyes</p> <p>*If BOTH eyes, do you agree that the initial eye's injection and the second eye's injection will be administered at least 6 days apart?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Has the patient received Luxturna previously?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>*If yes, which eye(s) were previously treated?</p> <p><input type="checkbox"/> Left eye <input type="checkbox"/> Right eye</p> <p>*If treating the additional eye, do you agree that the initial eye's injection and the second eye's injection will be administered at least 6 days apart?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Documented diagnosis of biallelic RPE65 mutation-associated retinal dystrophy confirmed by genetic testing? (please include genetic testing results)</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Authorization: once per lifetime</p>
Zolgensma	Authorization: once per lifetime